

MARIN COUNTY
FY 2002/03
HOSPITAL UNCOMPENSATED CARE RELIEF PAYMENT PROGRAM RULES
FOR EMERGENCY MEDICAL SERVICES
UNDER
SB 12/612 (MADDY) & AB 442 (EMSA)

OVERVIEW

The Marin County Department of Health and Human Services administers its Emergency Medical Services Fund pursuant to Chapter 1240, 1987 Statutes (“SB12-Maddy”), Health and Safety Code Part I, Division 2.5, Section 1797.98, in order to make relief payments for certain uncompensated emergency services. The Marin Emergency Services Fund is administered in three accounts; the Hospital Services Account; the Emergency Services/Trauma Account and the Physician Services Account. Up to 10% of the fund is set aside for administrative expenses. This document describes the policy and procedures applying to administration of the Hospital Services Account.

REIMBURSEMENT FROM THE HOSPITAL SERVICES ACCOUNT

Covered Services

1. The services must not have been compensated through any other source of payment, including private insurance, Medi-Cal or MediCare, or patient payments. Payment must have been unsuccessfully sought at least twice and payment from the Fund cannot be sought until three months after the first attempt to bill the patient or responsible third party.
2. Services must be provided in a general acute care hospital that provides basic or comprehensive emergency services.
3. The services must be related to emergency medical conditions as defined in Health and Safety Code Section 1317.1 and must be provided within 48 hours of the emergency incident.
4. Once the patient is stabilized, even if it is within the initial 48 hour period, no services will be covered.

RELIEF PAYMENT CLAIM PROCESS

1. **Enrollment**

Hospitals must be enrolled in the program before they can submit a claim: In order to enroll, an Affidavit of Certification for Participation in Uncompensated Care Fund (see Attachment A) must be submitted to the Marin County Department of Health and Human Services, as noted on the form.

2. **Information Required on Claim Submission**

Hospitals should submit the following data on a quarterly basis:

- The number of uncompensated emergency room visits provided each quarter;
- The hospital charges for these uncompensated emergency rooms visits.

3. **Eligible Services**

Emergency services that are covered: The services must be:

- a. Related to emergency medical conditions as defined in Health and Safety Code Section 1317.1*;
- b. Must be provided within 48 hours of the emergency incident.
- c. Once the patient is stabilized, even if it is within the initial 48 hour period, no services will be covered.

4. **There must be no other payment for the services.**

The hospital must be able to verify that:

No payment has been received after at least two billing attempts: The patient or responsible third party must have been billed at least twice, with no payment received or with a formal notification that no payment is forthcoming.

* 1317.1. Unless the context otherwise requires, the following definitions shall control ...:

(a) (1) "Emergency services and care" means medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery by a physician necessary to relieve or eliminate the emergency medical condition, within the capability of the facility.

(2) (A) "Emergency services and care" also means an additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition, within the capability of the facility.

...

(b) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- (1) Placing the patient's health in serious jeopardy.
- (2) Serious impairment to bodily functions.
- (3) Serious dysfunction of any bodily organ or part.

(c) "Active labor" means a labor at a time at which either of the following would occur:

(1) There is inadequate time to effect safe transfer to another hospital prior to delivery.

(2) A transfer may pose a threat to the health and safety of the patient or the unborn child.

...

(j) A patient is "stabilized" or "stabilization" has occurred when, in the opinion of the treating provider, the patient's medical condition is such that, within reasonable medical probability, no material deterioration of the patient's condition is likely to result from, or occur during, a transfer of the patient as provided for in Section 1317.2, Section 1317.2a, or other pertinent statute.

Requests for payment should be submitted to:

Office of Finance – Hospital Services Accounts
Attention: Linda Fortelka
20 North San Pedro Road, Suite 2028
San Rafael, CA 94903

COUNTY PAYMENT PROCESS

1. Availability of Monies

There is a set amount of money for paying hospital claims. Payment of hospital claims is contingent upon the County receiving monies, and sufficient money remaining in the account to pay claims. Payment of hospital claims will be processed for the period until the funds in these Hospital Services Accounts are exhausted or on a prorated basis if total claims exceed available funds.

2. No Other Reimbursement for Indigent Care

The County is not obligated to make payments to hospitals for uncompensated patient care services except as expressly provided for in these program rules and claim procedure.

3. Patient Confidentiality

The County shall protect the confidentiality of the patient information submitted and comply with all applicable federal, state, and local statutes and regulations governing the protection of patient medical information.

REFUNDS TO COUNTY

If, after receiving payment from County under this Uncompensated Care Relief Payment Program for uncompensated patient care services, the provider receives any payment from the patient or responsible party for the same services, the hospital shall notify the Marin County Department of Health and Human Services Office of Finance, and County's payment on any subsequent claim submitted by the hospital shall be reduced accordingly by the amount of the payment received from the patient or responsible party, but not to exceed the amount paid by the County for this same service. In the event that there is no subsequent submission by the hospital of a claim to the County for uncompensated services within one year of such notice, the hospital shall refund to the County an amount equal to the amount collected from the patient or responsible party, but not to exceed the amount of County's payment for the same patient care services.

PROVIDER RECORDS, AUDIT, AND PAYMENT ADJUSTMENT OBLIGATIONS

1. The provider shall maintain complete and accurate records sufficient to fully and accurately reflect the services and costs for which a claim has been made. Such records shall include, but are not limited to, patient name and identifying information, services provided, dates of service, charges, and payments received. Additionally, such records shall include proof of all billing efforts made and required by these rules.
2. All such records shall be retained by the hospital for a minimum of three years following the

date of service.

3. Such records shall be made available to representatives of County's Auditor-Controller and Health Services Department, and to representatives of the State, upon request, at all reasonable times during such three-year period for the purpose of inspection, audit, and copying.
4. If an audit, conducted by County or State representatives, of physician or hospital records, or both, relating to the services for which a claim was made and paid hereunder, finds that (1) the records do not support the emergency medical nature of all or a portion of the services provided, or (2) no records exist to evidence the provision of all or a portion of the services, or (3) the hospital failed either to report or refund payments from other sources as required herein, or (4) the records do not substantiate the required billing and collection efforts, the hospital shall, upon receipt of County billing therefore, remit forthwith to the County the difference between the claim amount paid by the County and the amount of the adjusted billing as determined by the audit.

APPEAL PROCEDURES

Disputes regarding rejection of claims, amount of payment, or any other issue related to this claim procedure must be filed with the County Health Services Department's Chief Fiscal Officer within 30 days of payment or denial of the claim. The County is not responsible for damages or costs which result from either the disputed action or the filing of an appeal.

Mail appeals to:

Frima Stewart, Director, Health Services Division
Health and Human Services Department
20 North San Pedro Road, Suite 2028
San Rafael, CA 94903

Appeals that cannot be resolved at this level shall be submitted to an arbitrator, pursuant to the California Code of Civil Procedures, Title 9, Chapter 3 (commencing with Section 1282) and Chapter 4 (commencing with Section 1285).

EFFECTIVE DATE

This procedure is effective June 15, 2004 and will apply to claims submitted for service dates starting April 1, 2004. Claims received after that date will only be processed if consistent with this procedure.

Attachments

- A: Affidavit Provider Enrollment Form
- B: Claim Verification Form

ATTACHMENT A – Affidavit of Certification for Participation in Uncompensated Care Fund

On behalf of _____ (name of hospital) I certify that all information provided as part of claims for reimbursement for uncompensated emergency care costs will meet the following conditions:

1. The services will have been provided as part of the treatment needed to stabilize the patient from an emergency condition.
2. That all reasonable attempts will have been made to ascertain whether the client was eligible for any kind of insurance, including Medi-Cal, including as appropriate soliciting identification information such as social security numbers.
3. The patient or responsible party will have been billed at least twice, no payment will have been received for these services, and it will have been at least 90 (ninety) days since the first billing attempt.
4. That all claims will be submitted in accordance with existing programs rules.

By: _____ Dated: _____
(Authorized Signature of Hospital Representative)

(Typed or Printed Name or Title of Hospital Representative)